

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 2 1

2. STATE:

MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

10-01-01

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 01 \$ 0b. FFY 02 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to attachment 3.1A & B Serv 4b
Page 1 of 1
Supplement to attachment 4.19B, Serv 4b
page 1 of 19. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Supplement to attachment 3.1A & B serv 4b
page 1 of 1
Supplement to attachment 4.19b serv 4b
page 1 of 1

10. SUBJECT OF AMENDMENT:

Clarifying reimbursement language & clarify experimental services - 3.1A - 3.1B

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Single state agency

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Gail Gray

14. TITLE:

Director

15. DATE SUBMITTED:

10-01-01

16. RETURN TO:

DPHHS
Gail Gray
PO Box 202951
Helena MT 59620-2951
Attn: Denny Gemmell**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

October 3, 2001

18. DATE APPROVED:

12/17/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/01/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Spencer K. Ericson

22. TITLE:

Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: October 2, 2001

MONTANA

The following limitations apply to Early Periodic Screening Diagnosis and Treatment Services. Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
2. All procedures and items, except prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions. Prescribed drugs approved for use under investigational drug status by the approved federal drug administration and provided under specific controlled medically supervised programs, under the supervision of a physician licensed to practice medicine are not considered experimental for persons eligible for EPSDT.
3. All procedures and items, including prescribed drugs, considered experimental but not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Montana will meet the requirements of Section 1905(r) of the Social Security Act and provide for the medically necessary service for which coverage is mandated by Section 1905(r).

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The Department will reimburse Medicaid providers for EPSDT services based on the lower of:

1. the provider's usual and customary (billed) charge for the service;
2. the Department's fee schedule; or
3. when the Department has not established a fee schedule, a rate negotiated with the provider.

TN No. 01-021

Supersedes TN No. 44-007

Approval Date 12/17/01

Effective Date: 10/01/01